President Kennedy and Addison's Disease

To the Editor:—Dr. John Nichols presents a convincing argument (201:115, 1967) that the late President John F. Kennedy suffered from Addison's disease and was the third of three cases in the paper by Nicholas et al.[1] After giving strong circumstantial evidence in support of his hypothesis, he attempts to show that it is logically impossible for the late President not to have had Addison's disease. This is circular reasoning.

Dr. Nichols says:

> It is most unlikely that two persons with the same age and clinical history of the late President would have undergone similar surgery in the same hospital on the same day and returned on exactly the same time four months later for removal of the plates. If so, Nicholas et al would have illustrated their paper with four cases instead of three.

Dr. Nichols uses the above argument to prove that Nicholas' third case could have been none other than President Kennedy. This argument is circular because it assumes what it attempts to prove, that President Kennedy had Addison's disease. If two patients of the same age and the same clinical history had been admitted to the same hospital on the same dates, one with Addison's disease and one without (the latter, for the purposes of this argument, President Kennedy), Nicholas would not have had a fourth case because he was writing only about surgery in addisonians.

Dr. Nichols has tried to use logic to show that the circumstantial evidence he has given proves conclusively that President Kennedy had Addison's disease. The circumstantial evidence is splendid; the logic is less so.

Neil A. Kurtzman, MD
Dallas

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1. Nicholas, A., et al: Management of Adrenocortical Insufficiency During Surgery, *Arch Surg* 71:737-742 (Nov) 1955.

To the Editor:—Following publication I have received 38 unsolicited letters from lay persons, apparently based on newspaper articles, many enclosing clippings. Twenty were anonymous and hostile! The other 18 were complimentary and signed.

Reprint requests have been mostly from practitioners, not associated with institutions. Only a few have been on preprinted request cards. Of the 125 requests, nine are two-page letters from former interns and residents who had been clinically associated with the Kennedy case some time previously. Others were from eminent authorities, one of whom says he was at one time Kennedy's personal physician. All agree with the diagnosis. No adverse criticism has been received from a physician.

John Nichols, MD
Kansas City, Kan

The Journal has received only a few comments, one from a technician, only indirectly related to the Kennedy case. A complimentary note was received from Ronald F. Garvey, MD, of Dallas, and another physician expressed the view that the Kennedy adrenal glands were privileged to the family, and not subject to public curiosity. Oscar W. Haffke, MD, of Fort Worth, Tex, said, "The pathological reports on the President's death are adequate. There is no need to be rehashing this situation at such late date; it will accomplish nothing."—Ed.

Metal Sensitivity and Duodenal Ulcer

To the Editor:—Recently I have been impressed with a series of cases in which the presenting complaint was the common problem of metal sensitivity. These patients are for the most part sensitive to nickel, which is alloyed into a large number of metallic products which contact the skin, eg, jewelry, buckles, garters, and snaps. I have been impressed by the considerable number who have a history of active or healed duodenal ulcer (x-ray-proven). Whether this observation is true to the point of being able to withstand controlled study is difficult to say. Since our knowledge of the pathogenesis of duodenal ulcer is incomplete, conjecture regarding something more than a coincidence between the metal sensitivity and the ulceration could be useful and worthy of presentation.

Cross sensitivity reactions between contact dermatitis of the skin and the mucosa have been demonstrated, as in acrylic dermatitis due to dentures. Whether this mucosal sensitivity analogy might be extended to the mucosa of the intestinal tract is a question. Cross sensitivity between nickel dermatitis and those due to chromium and cobalt have been demonstrated. Other metals which might be considered are iron, copper, manganese, and zinc. It would seem possible that metallic irritation of a predisposed area
of intestinal mucosa in a predi
individual could lead to a w
ing of resistance to the pro
peptic digestion. Whether or
ceration of the skin from c
probably due to chromate, or
tion of the nasal mucosa
chromic acid fumes in industr
any bearing in this matter ar
points.

Hyperhidrosis is a frequent
tom in patients with metal d
tis, perhaps with the sweat w
as a leaching agent. This s
overactivity of the sympathe
vous system as another
common denominator betwe
changes and peptic ulcer.

Undoubtedly the first
ment is to determine wheth
is an actual increase in d
ulceration in patients wit
dermatitis.

Barton L. L
Colorado Spri

Cyanoacrylate Tissue Adhesives

To the Editor:—The
"Cyanoacrylate Tissue Ad
(201:195, 1967) deserves c
Experimental observations
demonstrated a dichotomy
the alkyl-2-cyanoacrylates i
to local toxicity. The met
ethyl esters are locally toxi
higher homologues, such as
n-pentyl, n-hexyl, and n-d
not. We did not report[1] tha
proceeds up the homologo
histotoxicity decreases," b
showed that the methyl h
was logically toxic whereas
and decyl homologues w
The latter two materials
similar responses.

In regard to rates of po
tion, these rates can be
any monomer. They are di
lated to purity of the mon
face area exposed to cata
effective catalyst concentr
are inversely related to
concentration of acidic inh
stances. These factors,
purity of the monomer, co
merization time. Thus fac
than rate of polymerizatio
cific batch of a monomer
that monomer's experim
clinical acceptability.

It is stated that "high
ogous monomers have
disadvantage over the met
acrylate, namely, slower
ity." Recalling that non
sutures are chosen over